TECHNICAL NOTE NO. CAR/KYR-2/НАУЧНЫЙ ДОКЛАД CAR/KYR-2

Recommendations: Strategy for Health Facility Accreditation/ Рекомендации по Стратегии аккредитации учреждения здравоохранения

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Recommendations: Strategy for Health Facility Accreditation/ Рекомендации по Стратегии аккредитации учреждения здравоохранения

July 1995/Июль 1995

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Submitted by the Zdrav*Reform* Program to:
AID/ENI/HR/HP
AID Contract Number: CCN-0004-C-00-4023-00

RECOMMENDATIONS:
STRATEGY FOR HEALTH FACILITY ACCREDITATION

This document presents the recommendations for the creation of a system of standards and accreditation for hospitals and polyclinics. These recommendations are compatible with the regulations of the Ministry of Health in Bishkek, and present a guide to the creation and implementation of a workable system of accreditation.

The main purpose of any system of accreditation is the improvement of the quality of care delivered in health facilities. As such, the primary goal of the accreditation process should be *education*. When hospitals and polyclinics are inspected as part of the process, the assessors should aim not to find fault but rather to find solutions to the problems uncovered. With this goal of education and problem solving, the accreditation process will increase the quality of care delivered, and will provide hospital and polyclinic personnel with a guide to making future improvements.

Definitions: Standards and Quality

Definition of basic terms will help members of the medical community understand the relationship of accreditation, quality assurance, and the new mandatory health insurance (MHI) fund. To give all medical personnel of the Issyk-kul a common understanding of these activities, the following definitions should be used.

Three types of standards are important:

1. *Facility standards* are guidelines and indicators for the structure, equipment, staff, and operations of health care delivery facilities. The main purpose of these facility standards are to measure and judge facility performance in an accreditation process.

2. *Medical economic standards* (MES) measure the delivery of medical care services and judge the adequacy of the care delivered compared to a defined protocol of tests, treatments and outcomes. Medical economic standards primarily are used as a method of calculating services rendered in order to pay insurance claims under the mandatory health insurance fund. MES also can indicate the quality of medical care by exposing undesirable practices or outcomes in the categories of criteria of quality and criteria of complexity, and by uncovering nonperformed services in the categories of tests and treatments.

3. *Quality assurance standards* are guidelines for the in-depth investigation of medical practices in order to indicate the quality of medical care.

Quality of medical care is defined as achievement of the greatest reductions of morbidity and mortality possible given available resources and knowledge.

Types of Accreditation Systems

The improvement and maintenance of the quality of patient care is the main goal of any system to accredit hospitals and polyclinics. To achieve this goal, an organizational structure and methodology is needed for hospital accreditation that includes the development of facility standards and monitoring the compliance of hospitals and polyclinics to the facility standards. Several methods exist to accomplish this result. The first is for the government to set facility standards and monitor performance. Although this alternative has good points, the critical input of health care practitioners is not assured; thus the system that evolves may be inflexible and too restrictive on innovation and progress.

Another alternative is a *payer-driven system*, where facility standards are enforced by the payers of medical care. Government agencies that pay the costs of health care, or insurance companies that reimburse physicians and hospitals, may require compliance with certain facility standards before a provider is able to collect fees. In the development of the MHI program, a key ingredient should be the requirement of compliance to facility standards for reimbursement for health care services.

A third alternative is the *peer system* such as that used in the United States. This system has the advantage of operation by the health care providers themselves; as such it has a very high level of technical validity. The weakness of this system is its heavy reliance on practitioners to police their own ranks. An example of the effectiveness of the peer method can be seen in the work of the U.S. Joint Commission for the Accreditation of Health Care Organizations (JCAHO). JCAHO is responsible for setting U.S. hospital standards and for monitoring the compliance of hospitals to these standards. A hospital that substantially meets these facility standards is accredited. Although JCAHO is a private, nongovernmental organization created by the medical and hospital associations, its facility standards are very high, and the earning of accreditation carries considerable weight. Many states require their hospitals to earn JCAHO accreditation in order to receive a hospital license. They can do so with confidence because JCAHO is very strict in adhering to facility standards.

An example of a shortcoming of the peer system is the control of medical licenses by some state medical societies. Although the initial granting of medical licenses follows strict guidelines, in some states revocation of licenses from incompetent practicing physicians is poorly controlled. Physicians are reluctant to complain about their fellow practitioners in cases of incompetence, and medical societies are wary of taking disciplinary action, even when unacceptable behavior has been reported.

Accreditation Council

Kyrgyzstan should consider the option of an accreditation council run jointly by the mandatory health insurance program, the Ministry of Health, and the Physicians' Association. The accreditation council would be responsible for the development and enforcement of facility standards. This body could benefit from the technical responsiveness of a peer organization, the financial incentives of an insurance system, and the enforcement power of a governmental organization.

The creation of this body would allow medical professionals to set the facility standards by which they would be expected to practice, and would assure shared influence over the future directions of health

care by the MHI, government, and medical professionals. In the near term, the organization would be responsible for the development and updating of facility standards; the monitoring of hospital and polyclinic compliance with those standards; and the imposition of sanctions and penalties on those organizations failing to meet the standards after sufficient warning and time to achieve compliance. In the more distant future, the role of this organization could expand to cover the practice of individual physicians, the operation of rural ambulatory centers, and feldshers.

Accreditation Council Authority

An accreditation council would need the authority to inspect hospitals and polyclinics and to impose penalties and sanctions on those that do not comply with facility standards. Withholding of insurance payments is a major sanction that could be imposed in case of serious noncompliance.

Accreditation Council Funding

The accreditation council will require funding in order to carry out its duties. Although the development of hospital facility standards can be accomplished at minimal cost, the completed standards will need to be reviewed, word processed, edited, and published. The organization will require a number of full-time and part-time paid staff to disseminate the facility standards and to carry out the inspection and accreditation process. Although these costs can be kept to a minimum, a certain level of start-up and operational funding will be needed. Several possibilities should be considered: hospitals and polyclinics pay for inspections in order to become accredited; hospitals and polyclinics pay an annual fee; the government provides start-up funding; and the government pays operational costs.

Facility Standards Development

The first task to be undertaken by the accreditation council will be the development of *facility standards*. Then *Standards Committees* composed of experts in each of the relevant fields should develop the actual standards. The section below describes a process that the committees could follow in the writing of facility standards, components of which are reviewed in brief.

Facility Standards Accomplishments

- Facility standards must serve to educate relevant staff, managers, and practitioners on what constitutes minimum acceptable and preferable practice in the delivery of health care;
- Set minimums for quality of care, but encourage superior performance;
- Force an improvement in conditions and practices; and
- Provide, where possible, measurable indicators of quality of care.

Facility Standards Contents

- Facility standards describe minimal acceptable practice, equipment, facilities, personnel, or personnel qualifications;

- They illustrate "ideal" practices and conditions at a level achievable by hospitals and polyclinics; and

- They are specific enough to guide actions but are broad enough to allow adaptation to local circumstances.

Attachment 1 is an example of the facility standards set for the Ministry of Health, Arab Republic of Egypt. They were developed through the same committee process proposed for the formulation of the accreditation council's facility standards. The committee that developed Egypt's facility standards first examined those of the U.S. accreditation organization, JCAHO, to understand the contents of successful standards. The U.S. standards were then put aside, and a single committee member wrote new facility standards based on what he believed were realistic practices achievable in Egyptian Ministry of Health hospitals. The standards committee then reviewed the member's draft, debated its merits, agreed on changes, and submitted the draft for publication. This procedure has proven to be successful, and should therefore be considered for use.

Another important task of the standards committees will be the updating of facility standards. These standards must keep pace with changes in technology and in the health care system. Only if facility standards are revised constantly will the accreditation program continue to have a positive effect on the quality of patient care. It is recommended that the standards committee reconvene every two years to review existing standards in the light of changes in the health system and make modifications to bring the standards up to date. The accreditation council would publish the changes and disseminate them to all hospitals and polyclinics covered by the accreditation system.

Standards Committee Process

The *committee process* proposed for formulating facility standards is a relatively simple procedure that can be completed in a reasonable period of time. The Egyptian facility standards comprise thirty sections covering all aspects of hospital operations. These standards were not all developed at the same time. Early in the process, areas of highest priority were selected for immediate attention while other, less critical sections were left for future examination.

The standards committee should consider as a model the guidelines adopted in 1965 by the Joint Commission for the Accreditation of Hospitals (the predecessor organization of today's U.S. JCAHO), *Standards for Hospital Accreditation* (Attachment 2). This more simple approach set out three sections covering the most critical factors of hospital operations. Although JCAHO facility standards have evolved into a very large and complex set (more along the lines of the Egyptian facility standards), many accreditation experts believe that the simpler approach of the 1965 hospital standards are more

practical. The Pan American Health Organization took a similar, simple approach in developing facility standards for three Latin American countries; Pakistan also opted for a streamlined hospital accreditation model.

Once the most critical areas in terms of effect on patient care are developed, the facility standards should be published and the process of hospital compliance and inspections begun. Those areas considered less urgent may be developed at a more liberal pace, and published and disseminated as periodic updates to the facility standards manual.

In brief, the committee process operates as follows.

- Accreditation council member organizations select committee members.

- They examine educational materials such as copies of the JCAHO and Egyptian facility standards, along with instructions on the development of facility standards, the members' assignment to specific tasks, and specifications on areas to be studied and drafted.

- Each member reviews the materials and develops a draft of key issues, procedures, and technology elements that, in the member's opinion, should be included in the facility standards.

- Members convene a committee meeting to:

    1. Discuss and review the development process and the goals of facility standards, particularly in the technical area under consideration;

    2. Discuss the key issues, procedures, and technological elements contained in the members' drafts;

    3. Select a lead writer for each facility standards section, specify who will review the material developed, and work out details of the review process; and

    4. Give copies of drafts to lead writers and set timetables for completion of section drafts and for draft review.

- Lead writers produce drafts of facility standards sections and forward them to reviewers.

- Reviewers propose changes and/or write alternatives.

- The committee reconvenes to:

    1. Formally review the draft sections and proposed changes/alternatives;

2. Agree on and write final draft of facility standards section; and

3. Forward the completed draft to the accreditation council.

- The accreditation council reviews, word processes, edits, publishes, and disseminates a *Facility Standards Manual* to all hospitals and polyclinics.

This process, if diligently followed, should be able to publish the first version of a manual within four months. Again, this manual may not be complete, but it would cover those sections critical to beginning the accreditation process.

Monitoring Hospital and Polyclinic Compliance (Accreditation)

Once facility standards are completed, published, and disseminated, hospitals and polyclinics that are covered by the accreditation program will need to establish programs to bring them into compliance with the facility standards. The accreditation council should set a grace period for hospitals and polyclinics to achieve compliance with the new standards. During this period, hospitals and polyclinics can study the facility standards and begin programs to meet them.

The accreditation council will begin inspecting hospitals and polyclinics on a voluntary basis during this period as part of the learning process for both the institutions and the council. The results of these first inspections should be nonbinding in cases of failure to meet these standards but should award accreditation for those facilities that pass inspection. Accreditation should be given for a period of three years with renewal based on reinspection. As an incentive to hospitals and polyclinics to gain accreditation during the grace period, accredited status would begin immediately upon passing and would last for three more years.

Hospital and polyclinic inspections should occur for the following reasons:

- To gain accreditation;

- To renew accreditation; and

- In response to complaints of unsafe practices that endanger the lives of patients or hospital staff.

The committee should consider how the results of an inspection will be judged. One possibility is to have the inspectors pass judgment on the hospital based on the results of the inspection and on their own impressions. The second possibility is to weight the facility standards (either all facility standards or those on the *Instrument*) and assign a numerical score for level of compliance. The hospital would pass inspection based on achieving a certain total score. For example, on a 1,000-point scale, institutions rating 800 or better would pass and become accredited, while those with less would fail.

The results of the inspection would be forwarded to the accreditation council, which would review the inspector's report. Based on the inspector's recommendations or the inspection score, it would make a determination on accreditation and send a copy of the report to the ministry and the institution's head doctor. If the hospital passed, a certificate of accreditation would accompany the report to the head doctor.

Other issues to be decided are: who will be accreditation council inspectors; what skills should the inspectors have; and how many inspectors will be sent to inspect a hospital or polyclinic. It is vital that inspectors be qualified to judge the technical status of a facility, but the specialties represented on the inspection team are open to debate. It is suggested that at a minimum, four technical areas be represented on each team. Those areas are:

- Administration/management to review financial, general, and logistics management of the hospital;
- Medical/surgical to review medical and surgical services;
- Nursing to review nursing services and patient care; and
- Technical to review diagnostic (x-ray, lab, etc.) services.

Finally, it is important how the inspection is carried out. The main function of the inspection process should be educational. The inspection should be conducted in the presence of responsible parties at the hospital, and problem areas should be identified and discussed. The aim of the inspection process should be to uncover problem areas and work out corrections to the problems.

Above all, the inspectors should offer solutions and alternatives to problems found, not just criticism.